Cabinet for Health and Family Services
Office of Health Policy
Data Advisory Subcommittee
Thursday, March 18, 2010
1:00 PM – 3 PM
Public Health Auditorium, Suite A

Agenda

I. Welcome and Opening Remarks

II. Approval of Minutes (December 16, 2009)

III. Status of Data Reporting Regulation

IV. Status of Data Reporting for Ambulatory Facilities

V. KHA Data Collection Contract

VI. Update from KHA

   a. Introduce new staff
   b. KHA/State Data collection program

VII. Patient Identifiers/E-Health

VIII. Dates for Next 4 Meetings

Cabinet for Health and Family Services
Office of Health Policy
Data Advisory Subcommittee
Wednesday, December 16, 2009
1:00 PM – 3:00 PM
Public Health Distance Learning Center

MEMBERS PRESENT:

James Berton King's Daughters Medical Center	Ron Crouch Education and Workforce Development Cabinet	Carol Ireson University of Kentucky
Louis Kurtz Dept. for Mental Health Developmental Disabilities, and Addiction Services	Dr. John Lewis	Tim Marcum Baptist Hospital East
Chuck Warnick Kentucky Hospital Association	Ben Yandell Norton Healthcare	

MEMBERS ABSENT:

Sherill Cronin, Ph.D. Bellarmine University	Dr. Ruth Shepherd Department for Public Health	Paul Sinkhorn

STAFF: CHFS, Department for Public Health
Charles Kendell

CHFS, Office of Health Policy
Carrie Banahan Kris Hayslett Allison Martinez
Beth Morris Chandra Venettozzi

Dept. for Mental Health, Developmental Disabilities, and Addiction Services
Hope Barrett

GUESTS: Susan Tipton, Cull, Hayden and Vance
Martha Riddell, DrPH, University of Kentucky
Andy Johnson, PhD, UK College of Public Health

CALL TO ORDER

Charlie Kendell called the meeting to order in the Public Health Distance Learning Center, Frankfort.

WELCOME AND OPENING REMARKS

Charlie updated the group on the Department for Public Health's efforts during the H1N1 pandemic which began in early August. Though there is still widespread H1N1, cases are beginning to taper

off. DPH is monitoring the situation closely in the event that it should reoccur during January and February. The CDC warns that pandemics often occur in waves. The hope is that there will be enough people immunized to counteract a second wave.

APPROVAL OF MINUTES

Minutes from the meeting of September 17, 2009, were approved as distributed.

REGULATION 900 KAR 7:030 – DATA REPORTING BY HEALTH CARE PROVIDERS

Chandra informed the group that the regulation was filed on November 13 and no comments have been received. Comments are due by the end of December.

REPORTS REQUIRED BY STATUTE THAT HAVE BEEN FILED WITH LRC

The Cabinet is required to submit an annual report on the operations and activities of the Cabinet under KRS 216.2920 through 216.2929. Also biennially, the Cabinet is required to submit a report on comparative health-care charges, quality, and outcomes. These two reports have been filed with LRC and the Governor. These reports are available on the Office of Health Policy website in the Data Resource Gallery. In addition, biennially, the Cabinet is required to submit a report on the special health needs of the minority population in the Commonwealth. Torrie Harris, Director of the Office of Health Equity, took the lead in producing this report and a draft copy of the report was shared with the subcommittee.

REPORT ON NON-COMPLIANT HOSPITALS

The Cabinet has reviewed the DSVR reports that COMPData provided for the entire year of 2008 and the first two quarters of 2009. There were 23 facilities that were noncompliant for at least one quarter. KHA has written a letter to each of the 23 facilities advising them of their noncompliance. The Cabinet followed up with 20 of these facilities to advise them to become compliant by January 1, 2010. KHA then contacted the CEOs/Administrators for these facilities. If the agencies are not in compliance by the end of January, fines will be considered.

REPORT ON THE STATUS OF THE 28 AMBULATORY SURGERY CENTERS THAT NEED TO SUBMIT DATA

A little over a year ago, the Cabinet wrote to all the ambulatory facilities, which included ambulatory surgery centers, ambulatory care centers, specialized medical technology service providers, and mobile health service providers, and asked the facilities if they performed certain types of CPT codes. All 28 ambulatory surgery centers were identified as needing to submit data. The Cabinet has

contacted all of the facilities to advise them of the need to submit data. As of the end of the third quarter submissions, 14 facilities stated they were now submitting data. Another 9 facilities are testing, plan to begin testing in the near future, or plan to begin submitting data probably no later than first quarter 2010. Two facilities have just sent data reporting requirements/manuals to their vendors to begin the process and it is too soon to tell if these facilities will have problems. There are three facilities that the Cabinet knows will have significant problems. The Cabinet would like to go a little further into the process to get into the 15 specialized medical technology service providers and 2 mobile health service providers to determine how they are proceeding. At this point, there are about 6 months behind the ASCs. They are still testing and none are submitting.

PRESENTATION ON MONAHRQ

Allison Martinez provided an overview of the My Own Network – Powered by AHRQ (MONAHRQ). MONAHRQ will utilize our hospital discharge data and create a detailed website that allows users to go in and look at various quality and usage measures. It can present the data as maps, charts, rates and straight data. The base data can be input as often as we choose and the website updated. The software is downloaded to the user's computer, then the website it uploaded to our network. Since the Cabinet is a member of AHRQ, the software is free of charge.

ANNUAL HOSPITAL SURVEY – DISCUSS SECTION III, TABLE 15 – THERAPEUTIC AND DIAGNOSTIC CARDIAC CATHETERIZATION PROCEDURES BY FACILITY AND REGION

Carrie Banahan asked for the group's input on diagnostic and therapeutic cardiac catheterization services. This information is currently collected through the annual hospital utilization survey tool and can be extracted from the hospital claims data. Tim Marcum and Jim Berton both agreed that collecting the procedure codes would be more accurate. Carrie suggested meeting with KHA after the first of the year and coming up with a list of procedure codes to be collected. Carrie asked if there were other areas that are reported as part of the utilization survey process that could be collected using claims data. Ben Yandell stated that he liked the idea of pushing toward using procedure codes.

AMBULATORY SURGERY SERVICES ANNUAL SURVEY – WE HAVE RECEIVED A RECOMMENDATION THAT FACILITIES REPORT THEIR FACILITY UTILIZATION BY SPECIFIC CPT CODES RATHER THAN THE CURRENT METHOD

Beth Morris stated that the Ambulatory Surgical Survey has been revamped. The survey now consists of two sections. The first section is the standard ambulatory collection. In section 2, we are trying to

get down to the procedures performed in a procedure room. Over the last couple of years, there has been a huge trend for ambulatory facilities to open up procedure rooms. They have moved a lot of the procedures that were being performed in ORs to procedure rooms which caused their data to go down. As providers were reviewing the annual survey report, they disagreed with the numbers that they had submitted to the Cabinet. Beth explained that procedure room data could not be reported in the ambulatory OR data. Carrie asked when do facilities decide when it is will be considered an operating room or a procedure room? She asked if there were standards such as size or cleanliness. She also asked if Licensing had come in and inspected the rooms in question and if they had asked any questions. Tim Marcum responded that Licensing had reviewed the entire facility when they had received their license.

After reviewing the draft report, Beth and Chuck Warnick discussed that it would be advantageous to everyone to develop codes that went along with each of the procedures in Section 1. Chuck stated that if a procedure is performed in a surgical suite, there will be a revenue code that gives the number of hours or partial minutes that indicates the use of a surgical suite. If a endoscopic exam or other exam is performed in a procedure room, that code would be absent on the record submitted. By concensus and approval from the Cabinet, a list of codes would be created that would pare down those surgeries and if they had a corresponding revenue code for surgical time, it is truly considered a surgery. If there is no revenue code, then it is a procedure and it comes back to the billing data. Chandra Venettozzi asked if the surgery and procedure room data could be obtained using CPT and revenue codes without the facility having to do either. Chuck agreed, stating that if the surgical code and revenue code were absent, it had to have been performed elsewhere. Chuck stated that another factor is that there is a third place that procedures can be performed without surgical time and that is the Emergency Room. Charlie mentioned that the critical point from the Certificate of Need standpoint is the number of operations performed. Beth stated that under the new regulation, the Cabinet is changing the terminology from Surgical Centers to Surgical Services. These changes will go into effect for the 2010 survey cycle. Chandra also stated that we can not change 100% to claims data at this point because some of the ambulatory surgical centers are not reporting yet. KHA is currently in the process of hiring someone with medical coding experience to assist with the task. Chandra will schedule a meeting chaired by Chuck Warnick to further discuss this topic.

DISCUSSION ABOUT IMPLEMENTING A PERSON IDENTIFIER

Allison presented an overview of South Carolina's unique ID process and their legislation related to their data collection. Currently, that is a stumbling block in our data collection as legislation prevents

the Cabinet from collecting social security numbers and other identifiers that we would need to make those identifying numbers.

UPDATE ON IMPLEMENTATION OF DATA COLLECTION SERVICES BY KHA

Chuck reported that KHA signed an agreement on October 5 to purchase data collection software from Iowa Hospital Association. KHA's statewide data committee was involved in the selection process. KHA will continue to use the same file format. Job descriptions for the staff necessary to be added to KHA to manage the system have been finalized. They are in the process of interviewing candidates and will be hiring a coder with medical coding experience to provide assistance to hospitals and the Cabinet. They are also in the process of finalizing an agreement with a secure hosting entity. Data collections will be web-based, with the capability to make corrections online.. Entities required to submit receive an online message and have access to a secure website to make corrections to the cases that are found to be incorrect and resubmit them. KHA has already verbally informed COMPData that they will be discontinuing their agreement with them on June 30, 2010. KHA will be conducting web-based trainings for all data coordinators across the Commonwealth. Since the contract with the Iowa Hospital Association was signed, Chuck has been working on re-doing all the edits that are used to examine each record for quality and continuity. There are approximately 100+ edits that each record must pass. CMS edits are being used, as well as the edits created for the Iowa system, which are above and beyond the CMS edits.

ADJOURN

The meeting was adjourned.